REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request to inspect your protected health information in records that the Cancer Detection Section creates or maintains. You also have the right to request copies of those records. You will receive a response to your request within 30 days after you complete and we receive this form. If you want copies of your records, you must send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification (See Page 3). You may also be required to send documentation verifying your address (see Page 3). Mail this completed form to:

Cancer Detection Section
Attention: HIPAA
MS-7203, P.O. Box 942732
Sacramento, CA 94234-7320

<table>
<tr><th colspan="5">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="3">LAST NAME</td><td colspan="1">FIRST NAME</td><td>MIDDLE INITIAL</td></tr>
<tr><td colspan="3">ADDRESS</td><td colspan="1">CITY/STATE</td><td>ZIP CODE</td></tr>
<tr><td colspan="2">Cancer Detection Programs: Every Woman Counts
RECIPIENT ID NUMBER*</td><td>DATE OF BIRTH</td><td colspan="2">SOCIAL SECURITY NUMBER* (OPTIONAL)</td></tr>
<tr><td>DAYTIME PHONE NUMBER

(____) _____</td><td>ALTERNATE PHONE NUMBER

(____) _____</td><td>BEST TIME TO REACH YOU</td><td colspan="2">EMAIL ADDRESS</td></tr>
</table>

*We use these numbers to make sure your information goes only to you.
If you don't supply the numbers, we may ask you to get your Recipient ID Number from the place where you received our medical services.

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

THE CANCER DETECTION SECTION HAS THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION ABOUT PROGRAM CLIENTS. PLEASE CHECK WHICH TYPE(S) OF INFORMATION YOU WANT TO ACCESS BELOW.

☐ *SERVICES PROVIDED BY THE CANCER DETECTION SECTION*

☐ *INFORMATION OBTAINED FROM YOU DURING ENROLLMENT*

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION? (OPTIONAL)

FROM DATE	TO DATE

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL THE REQUESTED INFORMATION TO ME AT THE ADDRESS INDICATED ON PAGE 1.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON AT YOUR SACRAMENTO, CA OFFICE. PLEASE CONTACT ME TO SCHEDULE AN APPOINTMENT.

☐ I REQUEST THAT THE FOLLOWING PERSON BE ALLOWED TO INSPECT MY RECORDS:

NAME: _____

ADDRESS: _____

CITY, STATE ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____

RELATIONSHIP TO YOU: _____

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE_____ DATE_____

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

FOR ADDITIONAL VERIFICATION, PLEASE PROVIDE ANY PRIOR ADDRESSES FOR PERIODS WHEN YOU RECEIVED CANCER DETECTION SECTION SERVICES:

_____

ADDRESS CITY

_____

ADDRESS CITY

HAVE YOU RECEIVED SERVICES FROM THE CANCER DETECTION SECTION UNDER OTHER NAMES? IF SO, PLEASE LIST THE NAMES BELOW.

_____

LAST NAME FIRST NAME MIDDLE INITIAL

_____

LAST NAME FIRST NAME MIDDLE INITIAL

_____

LAST NAME FIRST NAME MIDDLE INITIAL

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.